DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 6 — 4 0 B

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.296

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $ 0
b. FFY 1996-1997 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24
*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24

10. SUBJECT OF AMENDMENT:
Disproportionate Share Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL:
09/26/96

21. TYPED NAME:
Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Operations

23. REMARKS: As per State request in letter dated May 1, 2000, NY 96-40 will be now split into NY 96-40 A and NY 96-40 B. This is an approval for NY 96-40 B only. Approved pages for adoption into the NY State Plan are as follows: Attachment 4.19-A Part I-234 and 235, Attachment 4.19-A Part II page 10,and 11,Attachment 4.19-A Part III page 2B, 2C,6, 7, Attachment 4.19-A Part IV page A1,A2. Attachment 4.19-A Part VI pages 1 and 2, Attachment 4.19-A Part VII pages 23and 24.

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 6 — 4 0 B

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.296

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $ 0
b. FFY 1996-1997 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24
*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24

10. SUBJECT OF AMENDMENT:
Disproportionate Share Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

17. [redacted]

18. [redacted]
09/26/97

21. TYPED NAME:
Sue Kelly [redacted] Administrator

23. REMARKS:
[redacted] split into [redacted] B. This is an approval for [redacted] July. Approved pages in the NY State Plan are as follows: Attachment 4.19-A Part I [redacted] Attachment 4.19-A Part II page 10 and 11, Attachment 4.19-A Part III [redacted] 2C, 6, 7, Attachment 4.19-A Part IV page A1, A2, Attachment 4.19-A Part VI pages 1 and 2, Attachment 4.19-A Part VII pages 23 and 24.

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 6 — 4 0 B

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.296

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $ 0
b. FFY 1996-1997 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24
*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24

10. SUBJECT OF AMENDMENT:
Disproportionate Share Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to DMSO: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

MAY 14 2001

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Novello:

This is to notify you that New York State Plan Amendment (SPA) #96-40B, concerning inpatient hospital services, has been approved for adoption into the State Medicaid Plan with an effective date of September 26, 1996.

This approval is based on the State's request dated May 3, 2001 that splits the original SPA into separate amendments, #96-40A and #96-40B. This letter concerns #96-40B only; the State will be notified separately about #96-40A.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of SPA #96-40B and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Kathleen Gormaley or Shing Jew of this office. Ms. Gormaley's telephone number is (212) 264-3124, and Mr. Jew may be reached at (212) 264-4459.

Sincerely,

Sue Kelly
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure: SPA #96-40B
HCFA-179 Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 6 — 4 0 B

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.296

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $ 0
b. FFY 1996-1997 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24
*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 234,235
Attachment 4.19-A Part II Pages 10,11
Attachment 4.19-A Part III Pages 2B,2C,6,7
Attachment 4.19-A Part IV Pages A1,A2
Attachment 4.19-A Part VI Pages 1,2
Attachment 4.19-A Part VII Pages 23,24

10. SUBJECT OF AMENDMENT:
Disproportionate Share Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL:
09/26/96

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Sue Kelly

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: As per State request in letter dated May 3, 2001, NY 96-40 will be now split into NY 96-40 A and NY 96-40 B. This is an approval for NY 96-40 B only. Approved pages for adoption into the NY State Plan are as follows: Attachment 4.19-A Part I-234 and 235, Attachment 4.19-A Part II page 10 and 11, Attachment 4.19-A Part III page 2B, 2C, 6, 7, Attachment 4.19-A Part IV page A1, A2. Attachment 4.19-A Part VI pages 1 and 2, Attachment 4.19-A Part VII pages 23 and 24.

Instructions on Back

Attachment 4.19-A
Part I

86-1.85 Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid- eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share payment described in sections 86-1.65, 86-1.74 and 86-1.84. However, the calculations of hospitals' bad debt and charity care experience used to determine the disproportionate share payments made under sections 86-1.65, 86-1.74 and 86-1.84, does not include costs of services to any person for whom an additional disproportionate share payment has been made under this section.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals ~~who~~which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.